City of Duluth

Employer Information Form

Please fax with Report of Injury to RTW, Inc. 1-866-286-5258

Injured Employee Name: _____ **Date of Injury:** _____

Form Completed By: _____ **Date of Birth:** _____

Today's Date: _____ **SSN:** _____

I. LOST TIME

A. Did the injured employee lose any time from work? Yes ____ No ____

B. Did the employee leave work to seek medical treatment? Yes ____ No ____

C. If yes, did he/she return to work after the appointment? Yes ____ No ____

D. When is the employee's next scheduled shift? _____

E. If the employee is disabled from working, when is his/her anticipated return to work date? _____

F. Please indicate the date(s) the employee missed work and the number of hours on each day:

_____

II. MEDICAL TREATMENT

A. Did the employee seek medical treatment? Yes ____ No ____

☐ If yes, where? _____

☐ If no, does the employee intend to seek medical treatment? Yes ____ No ____

B. Is a follow-up doctor appointment scheduled? Yes ____ No ____

☐ If so, when and where? _____

III. WORK STATUS

A. Is the employee currently working? Yes ____ No ____

B. Does the employee have work restrictions? Yes ____ No ____

☐ If yes, please send a copy of the work restrictions to RTW, Inc.

C. Has work been offered to employee within restrictions? Yes ____ No ____

☐ If yes and a written job offer has been completed, please send a copy to RTW, Inc.

IV. OTHER

A. Are there any concerns or issues with the employee or with the nature of the injury? Yes ____ No ____

B. Any additional comments:

Please contact your RTW Account Management Team with any questions